

3754

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b>		c. LENGTH OF STAY IN 1b <b>all her life</b> <b>X</b> <b>Berlin</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>P.O. Box 53</b>		d. STREET ADDRESS <b>P O Box 53</b>	
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>A</b> Last <b>Bowen</b>		4. DATE OF DEATH Month <b>3</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>FM</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/18/1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Doane</b>	
14. MOTHER'S MAIDEN NAME <b>Mary ? Doane</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Howard Bowen, Berlin, Md Box 53</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas with metastases</b> DUE TO <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>157X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic cholecystitis &amp; cholelithiasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-12</b> , 19 <b>59</b> , to <b>3-13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-13</b> , 19 <b>59</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ivory V. Sully, Jr.</b>		ADDRESS (Street, city or town, state) <b>Berlin Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Ivory Sully, Jr.</b>		DATE SIGNED <b>3/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/18/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berlin, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home, Salisbury, Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

3755 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
c. LENGTH OF STAY IN 1b <u>19.58</u>		d. STREET ADDRESS <u>R 203</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Garry Wayne Doughty</u> First Middle Last		4. DATE OF DEATH <u>3</u> Month <u>24</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19, 1958</u> 3 mo 4 yrs.
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Francis Doughty</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Elizabeth Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Ruth Elizabeth Doughty</u>		Address <u>Pocomoke MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia probably</u> 492x DUE TO (b) <u>Upper Respiratory Cold virus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>[redacted]</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>[redacted]</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius Jr.</u>		DATE SIGNED <u>3/24/59</u>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-26-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Burton</u>	22d. LOCATION (City, town, or county) (State) <u>Melba, VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>		24a. REC'D BY REGISTRAR <u>30</u> DATE <u>MAR 30 '59</u>	
Address <u>new church, VA.</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. L. &amp; H.</u>	

4000162XV6

STATE DEPARTMENT OF HEALTH—ATLANTA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3751

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42 Pocomoke City</b>			
c. LENGTH OF STAY IN 1b <b>14 months</b>				d. STREET ADDRESS <b>8 Clementine Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 Clementine Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>OCA</b> Middle <b>ELIZABETH</b> Last <b>EVANS</b>		4. DATE OF DEATH		Month <b>March</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 25, 1893</b>	
9. AGE (In years last birthday) yrs. <b>66</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William E. Wise</b>		14. MOTHER'S MAIDEN NAME <b>Gracie Collins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Grace Marshall, Pocomoke City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>463x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombo phlebitis of left leg</b> DUE TO (c) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>10 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Osteoarthritis @ Malnutrition</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/25/59</b> , 19 <b>59</b> , to <b>3/4/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/4/59</b> , 19 <b>59</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Cecil A. Duverney</b> M.D.				ADDRESS (Street, city or town, state) <b>801 - 4th St., Pocomoke</b>			
DATE SIGNED <b>3/7/59</b>				PHYSICIAN'S NAME (Type) <b>Cecil A. Duverney</b>			
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cool Spring Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Girdletree, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Watson</b>				ADDRESS <b>Pocomoke City, Md</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03747

3757

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>All her life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route #3</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Ann</u> Last <u>Foreman</u>		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>F.M.</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK LEONARD</u>		14. MOTHER'S MAIDEN NAME <u>ARLANTA TIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MR. CHARLES FOREMAN JR.</u>		Address <u>BERLIN, MD, Rt #3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cerebral thrombosis</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>5 yrs 4 mos</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-29</u> , 19 <u>53</u> , to <u>3-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-25</u> , 19 <u>59</u> , and that death occurred at <u>5:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ivory U. Suilly, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md</u> DATE SIGNED <u>3/28/59</u>	
PHYSICIAN'S NAME (Type) <u>IVORY U. SUILLY, JR. M.D.</u>		<u>BERLIN, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Newark, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart</u>		ADDRESS <u>FUNERAL HOME, Salisbury, Md</u>	
24a. REC'D BY REGISTRAR <u>APR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

[illegible]

3756

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>X BERLIN</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE HAROLD GOODMAN</b>				4. DATE OF DEATH Month Day Year <b>MAR. 4 1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 26, 1888</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CHICKEN PLANT</b>		11. BIRTHPLACE (State or foreign country) <b>ARDMORE PA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>GEORGE O. GOODMAN</b>				14. MOTHER'S MAIDEN NAME <b>ANNA SLATER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-18-4091</b>		17. INFORMANT Address <b>MRS. G. H. GOODMAN BERLIN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocarditis</b> 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>chronic myocarditis</b> DUE TO (c) <b>cardiac asthma</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-1</b> , 19 <b>55</b> , to <b>3-4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-1-59</b> , 19 <b>59</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clifford E. Schott</b> M.D. <b>Berlin Md.</b>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>CLIFFORD E. SCHOTT M.D. BERLIN, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>3/6/59</b>		<b>EVERGREEN</b>		<b>BERLIN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burbage</b> ADDRESS <b>Berlin Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. France</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3758

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>R.F.D.</u>	
3. NAME OF DECEASED (Type or print) <u>Paul Clifford Johnson</u> First Middle Last		4. DATE OF DEATH <u>Mar. 6 1959</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1942</u>
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Jones</u>		14. MOTHER'S MAIDEN NAME <u>Essie Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Essie Johnson, Bishop, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>744.1 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Muscular dystrophy</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 yr. 11 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-5</u> , 19 <u>57</u> , to <u>3-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-5</u> , 19 <u>59</u> , and that death occurred at <u>8:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ivory V. Sally, M.D.</u>		ADDRESS (Street, city or town, state) <u>Berlin, Md.</u> DATE SIGNED <u>3/6/59</u>	
PHYSICIAN'S NAME (Type) <u>Ivory V. Sally, M.D.</u>		<u>Berlin, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Mar. 8, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03749

Reg. Dist. No.

3759

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Church</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>J</u> Last <u>Saurs</u>		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-1897</u>
9. AGE (In years) <u>61</u> <u>4/24</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Peter J. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Lucie Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-32-7064</u>	
17. INFORMANT <u>Mr William Saurs</u>		Address <u>Snow Hill, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intra cranial Pressure</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic Breast Carcinoma</u> DUE TO <u>Breast Carcinoma</u> (c) <u>Breast Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1953</u> to <u>March 27, 1959</u> , that I last saw the deceased alive on <u>March 27, 1959</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay St</u> DATE SIGNED <u>3-28-59</u>			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		ADDRESS <u>104 Bay St</u> DATE SIGNED <u>3-28-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, MD</u>		ADDRESS <u>Snow Hill, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Emmis</u>		ADDRESS <u>Snow Hill, MD</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Hous</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hous</u>	

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH  
BOSTON

1  
M  
00  
I  
0  
1  
VS A15 (4)  
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03750

3752

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Sixth Street				d. STREET ADDRESS 209 Sixth Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CORA Middle M. Last LONG		4. DATE OF DEATH Month March Day 4, Year 19 59					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1882	9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irvin Mentzer				14. MOTHER'S MAIDEN NAME Rebecca Slippy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs A. J. Duncan, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Ventricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Minutes Years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Cardiac Asthma 2. Generalized Atherosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8, 1957, to Mar. 4, 1959, that I last saw the deceased alive on Mar. 4, 1959, and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles W. Trader, M.D.				PHYSICIAN'S NAME (Type) Charles W. Trader, M.D. 302 Market St., Pocomoke City, Md. 3/5/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-59		22c. NAME OF CEMETERY First Baptist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry St. Watson				ADDRESS Pocomoke City, Md.		24a. RECEIVED BY REGISTRAR MAR 9 1959	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3760

Items 6.14 Film G239 3-16-59 et

CERTIFICATE OF DEATH

03751

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleysville</u>				c. LENGTH OF STAY IN 1b <u>9 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>R-7.D.</u>			
3. NAME OF DECEASED (Type or print) First <u>Veronica</u> Middle <u>Rose</u> Last <u>Mahoney</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/14-1966</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Mahoney</u>				14. MOTHER'S MAIDEN NAME <u>William Rose Brady</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>Leonard Mahoney</u>			
17. INFORMANT <u>Whaleysville</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Attack</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-2-</u> , 19 <u>59</u> , to <u>3-7-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-2-</u> , 19 <u>59</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas R Lew</u> M.D.				ADDRESS (Street, city or town, state) <u>Burles Md</u> DATE SIGNED <u>3-7-1959</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary</u>		22d. LOCATION (City, town, or county) (State) <u>Coxsackie N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u> ADDRESS <u>Pocomoke City Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3761

## CERTIFICATE OF DEATH

03752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joe</u> Middle <u>Louis</u> Last <u>Mills Jr.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1959</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Stockton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>None</u>							
13. FATHER'S NAME <u>Joe Louis Mills Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Joe Louis Mills Sr., Stockton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>g</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>24 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/2</u> , 19 <u>59</u> , to <u>3/3</u> , 19 <u>59</u> that I last saw the deceased alive on <u>3/2</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John M. Bender</u> M.D.							
PHYSICIAN'S NAME (Type) <u>John M. Bender M.D. 104 Bay St. Snow Hill, Md.</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)				22b. DATE THEREOF <u>March 4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beneficial Society</u>	
22d. LOCATION (City, town, or county) (State) <u>Stockton, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Dennis</u> ADDRESS <u>Snow Hill, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3762

## CERTIFICATE OF DEATH

03753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BISHOP</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BISHOP</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>R.F.D.</b>			
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>ANN</b> Last <b>SELBY</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>6</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 11, 1880</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMIES TURBBS</b>				14. MOTHER'S MAIDEN NAME <b>MARY ANN ZULLEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <b>✓</b>		17. INFORMANT <b>DANIEL SELBY</b> Address <b>BISHOPVILLE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Myocardial insufficiency</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 9</b> , 19 <b>58</b> , to <b>March 6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>March 5</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Miss Harriet</b> M.D.				ADDRESS (Street, city or town, state) <b>Beggsboro Del.</b> DATE SIGNED <b>3-6-59</b>			
PHYSICIAN'S NAME (Type) <b>Arthur L. Hanna</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>3/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. O. O. F.</b>		22d. LOCATION (City, town, or county) (State) <b>Bishopville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Hanna</b> ADDRESS <b>Beggsboro Del.</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Case No. 100

Death: Page 4

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>10-25-1965</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Immediate cause: <u>MYOCARDIAL INFARCTION</u></p>	
<p>9. Contributing cause: <u>ATHEROSCLEROSIS</u></p>		<p>10. Manner of death: <u>NATURAL</u></p>	
<p>11. Signature of physician: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	
<p>13. Date of registration: <u>10-26-1965</u></p>		<p>14. Place of registration: <u>BALTIMORE</u></p>	

TC 10

## CERTIFICATE OF DEATH

03754

Reg. Dist. No.

3753

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42 Pocomoke City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12 Second Street</b>		d. STREET ADDRESS <b>1 12 Second Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MILTON</b> Middle <b>L.</b> Last <b>VEASEY</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1877</b>
9. AGE (In years last birthday) yrs. <b>81</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer and Banker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas J. Veasey</b>		14. MOTHER'S MAIDEN NAME <b>Marietta Richards</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No. --</b>		16. SOCIAL SECURITY NO. <b>216-12-1835</b>	
17. INFORMANT <b>Mrs May Y. Veasey, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(a) Pulmonary Edema; (b) Stokes-Adams Syndrome</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 9, 1955</b> to <b>March 27, 1959</b> , that I last saw the deceased alive on <b>Mar. 27, 1959</b> , and that death occurred at <b>640a. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles W. Trader</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>302 Market St., Pocomoke, Md. 3-27-59</b>	
PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethany Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Gallagher &amp; K...</b>	

MEDICAL CERTIFICATION

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SERVICE		12. PLACE OF DEATH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. CAUSE OF DEATH		17. MANNER OF DEATH		18. SIGNATURE OF PHYSICIAN	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF WITNESS		21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF CLERGYMAN		24. SIGNATURE OF JUDGE	